		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041269

Facility Name: Lemont Center

Address: 12450 Walker Road (Number) Lemont (City) 60439 (Zip Code)

County: Cook

Telephone Number: (630)243-0400 **Fax #** (630)243-5063

IDPA ID Number: 22-3401506001

Date of Initial License for Current Owners: 02/24/96

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL		
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State		
[ ]	Trust	[ ]	Partnership	[ ]	County		
IRS Exemption Code		[X]	Corporation	[ ]	Other		
		[ ]	"Sub-S" Corp.				
		[ ]	Limited Liability Co.				
		[ ]	Trust				
		[ ]	Other				

In the event there are further questions about this report, please contact:
Name: Laura Hillenbrand **Telephone Number:** (304)599-0395

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Glenn Adrian
(Title) Regional President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	26	Skilled (SNF)	130	38,090	1
2		Skilled Pediatric (SNF/PED)			2
3	124	Intermediate (ICF)	20	16,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,681	11,668	12,124	36,473	8
9	SNF/PED					9
10	ICF	3,526	12,021	82	15,629	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,207	23,689	12,206	52,102	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.16%

D. How many bed-hold days during this year were paid by Public Aid?
204 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/92

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/92 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 130 and days of care provided 12,021

Medicare Intermediary Riverbend Government Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lemont Center # 0041269 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	282,053	34,765	74,405	391,223		391,223	(4,477)	386,746			1
2	Food Purchase		257,946		257,946		257,946	(5,037)	252,909			2
3	Housekeeping	188,269	33,606	9,285	231,160		231,160	(522)	230,638			3
4	Laundry	64,421	16,935	4,536	85,892	79	85,971	(228)	85,743			4
5	Heat and Other Utilities			154,834	154,834		154,834		154,834			5
6	Maintenance	52,625	22,531	68,645	143,801		143,801	(154)	143,647			6
7	Other (specify):* Trash Removal			17,685	17,685		17,685		17,685			7
8	**TOTAL General Services**	587,368	365,783	329,390	1,282,541	79	1,282,620	(10,418)	1,272,202			8
	B. Health Care and Programs											
9	Medical Director			16,250	16,250		16,250		16,250			9
10	Nursing and Medical Records	2,957,066	364,256	703,796	4,025,118	1,729	4,026,847	(3,219)	4,023,628			10
10a	Therapy		21,765	859,809	881,574		881,574	(25,173)	856,401			10a
11	Activities	176,958	26,527	17,016	220,501	(180)	220,321	(6,602)	213,719			11
12	Social Services	127,626	164	46,018	173,808		173,808		173,808			12
13	Nurse Aide Training	27,781	(39)	2,674	30,416	335	30,751		30,751			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,289,431	412,673	1,645,563	5,347,667	1,884	5,349,551	(34,994)	5,314,557			16
	C. General Administration											
17	Administrative	270,192	990	2,558,764	2,829,946	(79)	2,829,867	855,061	3,684,928			17
18	Directors Fees											18
19	Professional Services			11,202	11,202		11,202	(9,527)	1,675			19
20	Dues, Fees, Subscriptions & Promotions			12,331	12,331	(2,645)	9,686	(875)	8,811			20
21	Clerical & General Office Expenses		31,668	117,307	148,975	26	149,001		149,001			21
22	Employee Benefits & Payroll Taxes			794,986	794,986	250	795,236	1,937	797,173			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,595	11,595		11,595		11,595			24
25	Other Admin. Staff Transportation			934	934		934		934			25
26	Insurance-Prop.Liab.Malpractice			54,090	54,090		54,090		54,090			26
27	Other (specify):* Misc Expenses			2,105,779	2,105,779	485	2,106,264	(2,106,052)	212			27
28	**TOTAL General Administration**	270,192	32,658	5,666,988	5,969,838	(1,963)	5,967,875	(1,259,456)	4,708,419			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,146,991	811,114	7,641,941	12,600,046		12,600,046	(1,304,868)	11,295,178			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lemont Center #0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			356,487	356,487		356,487	(38,157)	318,330			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							489,486	489,486			32
33	Real Estate Taxes			258,736	258,736		258,736		258,736			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			88,957	88,957		88,957	(12)	88,945			35
36	Other (specify):*											36
37	**TOTAL Ownership**			704,180	704,180		704,180	451,317	1,155,497			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			3,894	3,894		3,894		3,894			38
39	Ancillary Service Centers			417,014	417,014		417,014	(8,340)	408,674			39
40	Barber and Beauty Shops		230	39,270	39,500		39,500		39,500			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,350	82,350		82,350		82,350			42
43	Other (specify):*			6,441,915	6,441,915		6,441,915	(6,365,203)	76,712			43
44	**TOTAL Special Cost Centers**		230	6,984,443	6,984,673		6,984,673	(6,373,543)	611,130			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,146,991	811,344	15,330,564	20,288,899		20,288,899	(7,227,094)	13,061,805			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,876)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,034)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(38,157)	30		9
10	Interest and Other Investment Income	(483)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,161)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(30)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(9,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,087,304)	27		24
25	Fund Raising, Advertising and Promotional	(18,718)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,159,763)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,305,057		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,305,057		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (854,706)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Lemont Center

ID# 0041269

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Janitorial Expenses	$ 880	6	1
2	Recruiting Fees	1,937	22	2
3	Cable TV Expense	(6,569)	11	3
4	Cable TV Expense	(3,318)	10	4
5	PAC Dues	(720)	20	5
6	Books, Dues & Subscriptions	(155)	20	6
7	Non-recurring Charges	(6,365,203)	43	7
8	Contracted Nursing	1,287	10	8
9	Sr. BOM Collection Fee	(500)	19	9
10	Donation	(27)	19	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,372,388)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lemont Center # 0041269 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	(4,477)	0	0	0	0	0	0	0	0	0	(4,477)	1
2	Food Purchase	(5,037)	0	0	0	0	0	0	0	0	0	0	(5,037)	2
3	Housekeeping	0	(522)	0	0	0	0	0	0	0	0	0	(522)	3
4	Laundry	0	(228)	0	0	0	0	0	0	0	0	0	(228)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(154)	0	0	0	0	0	0	0	0	0	0	(154)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,191)	(5,227)	0	0	0	0	0	0	0	0	0	(10,418)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,031)	(1,188)	0	0	0	0	0	0	0	0	0	(3,219)	10
10a	Therapy	0	(25,173)	0	0	0	0	0	0	0	0	0	(25,173)	10a
11	Activities	(6,569)	(33)	0	0	0	0	0	0	0	0	0	(6,602)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(8,600)	(26,394)	0	0	0	0	0	0	0	0	0	(34,994)	16
	C. General Administration													
17	Administrative	0	855,061	0	0	0	0	0	0	0	0	0	855,061	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(9,527)	0	0	0	0	0	0	0	0	0	0	(9,527)	19
20	Fees, Subscriptions & Promotions	(875)	0	0	0	0	0	0	0	0	0	0	(875)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	1,937	0	0	0	0	0	0	0	0	0	0	1,937	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(2,106,052)	0	0	0	0	0	0	0	0	0	0	(2,106,052)	27
28	**TOTAL General Administration**	(2,114,517)	855,061	0	0	0	0	0	0	0	0	0	(1,259,456)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,128,308)	823,440	0	0	0	0	0	0	0	0	0	(1,304,868)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lemont Center # 0041269 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(38,157)	0	0	0	0	0	0	0	0	0	0	(38,157)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(483)	489,969	0	0	0	0	0	0	0	0	0	489,486	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	(12)	0	0	0	0	0	0	0	0	0	(12)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(38,640)	489,957	0	0	0	0	0	0	0	0	0	451,317	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(8,340)	0	0	0	0	0	0	0	0	0	(8,340)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(6,365,203)	0	0	0	0	0	0	0	0	0	0	(6,365,203)	43
44	**TOTAL Special Cost Centers**	(6,365,203)	(8,340)	0	0	0	0	0	0	0	0	0	(6,373,543)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(8,532,151)	1,305,057	0	0	0	0	0	0	0	0	0	(7,227,094)	45

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Genesis Health Ventures	100	See Attached List		Neighborcare	Willowbrook, IL	Pharmacy
				Genesis Rehab	Kennett Square, PA	Therapy
				Genesis Hospitality	Kennett Square, PA	Dietary

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest	$	Genesis Health Ventures	100.00%	$ 489,969	$ 489,969	1
2	V	17	Administrative		Genesis Health Ventures	100.00%	855,061	855,061	2
3	V	1	Related Party Mark-up	183	Neighborcare			(183)	3
4	V	10	Related Party Mark-up	1,188	Neighborcare			(1,188)	4
5	V	35	Related Party Mark-up	12	Neighborcare			(12)	5
6	V	39	Related Party Mark-up	8,340	Neighborcare			(8,340)	6
7	V	10a	Related Party Mark-up	69	Neighborcare			(69)	7
8	V	11	Related Party Mark-up	33	Genesis Rehab			(33)	8
9	V	10a	Related Party Mark-up	25,104	Genesis Rehab			(25,104)	9
10	V	1	Related Party Mark-up	4,294	Genesis Hospitality			(4,294)	10
11	V	3	Related Party Mark-up	522	Genesis Hospitality			(522)	11
12	V	4	Related Party Mark-up	228	Genesis Hospitality			(228)	12
13	V								13
14	Total			$ 39,973			$ 1,345,030	$ * 1,305,057	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Facility is owned by a publicly traded company.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Genesis Health Ventures
Street Address: 101 E. State Street
City / State / Zip Code: Kennett Square, PA 19348
Phone Number: (610)444-6350
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Costs		405	$ 185,300,553	$		$ 855,061	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 185,300,553	$		$ 855,061	25

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Mellon Bank Revolving Credit		X				$ 4,877,743	$ 4,877,743		10.0450	$ 489,969	1
2	Mellon Bank Revolving Credit		X									2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 4,877,743	$ 4,877,743			$ 489,969	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,877,743	$ 4,877,743			$ 489,969	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 370,959	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 268,764	2
3. Under or (over) accrual (line 2 minus line 1).		$ (102,195)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 360,930	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 258,736	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	110,863	8
	1997	226,113	9
	1998	248,291	10
	1999	266,255	11
	2000	268,724	12

Second Half Real Estate Tax payment recorded to Prepaids. This payment has been included in line 2 and removed from line 4.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lemont Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041269

CONTACT PERSON REGARDING THIS REPORT Laura Hillenbrand

TELEPHONE (304)599-0395 FAX #: (304)285-0624

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-27-300-048-0000	Long Term Care	$ 268,620.31	$ 268,620.31
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 268,620.31	$ 268,620.31

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility Use		1994	$ 326,452	1
2					2
3	TOTALS			$ 326,452	3

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150			1995	$ 7,265,030	$ 217,897	40	$ 181,626	$ (36,271)	$ 1,044,222	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Capitalized Interest			1996	99,787	2,482	40	2,494	12	13,139	9
10	Architecture			1997	338	8	40	8		37	10
11	Fire Prevention			1997	495	12	40	12		57	11
12	Temperature Control			1997	4,200	105	40	105		491	12
13	Construction Fees			1997	176,615	4,394	40	4,417	23	20,242	13
14	Plumbing			1997	2,967	74	40	74		320	14
15	Enviromental Service			1997	950	24	40	24		104	15
16	Engineering			1997	1,503	37	40	37		160	16
17	Site Lighting for Building			1997	690	20	35	20		85	17
18	Add lighting to Residents Dining Room			1998	1,854	48	35	48		192	18
19	Setting Up Dementia Unit Security System			1998	1,912	45	35	45		180	19
20	Install Counter in Therapy Office			1998	1,720	41	35	41		164	20
21	Water Softner Treatment			1998	1,100	26	35	26		104	21
22	Mixing Valve for Resident Whirlpool Tub			1998	480	11	35	11		44	22
23	Upgrade Multilink Electrical Unit			1998	370	9	35	9		36	23
24	Replace Compressor for Dietary Walk- In			1998	1,649	39	35	39		156	24
25	Upgrade Multilink Electrical Unit			1998	818	19	35	19		76	25
26	Hot Water Tank Replacement Valve			1998	800	17	35	17		68	26
27	Upgrade Multilink Electrical Unit			1998	2,483	48	35	48		192	27
28	Relocate Brass Pipeline & Valve			1998	492	7	35	7		28	28
29	Replace Fire Protection System Pipeline			1998	265	3	35	3		12	29
30	Replace Back Delivery Doors			1998	2,874	13	35	13		52	30
31	Replace Heating & A/C Duct Filter			1998	905	17	35	17		68	31
32	Improvements			1999	9,409	269	35	269		807	32
33	Roofing Repairs			2000	2,400	69	35	69		138	33
34	Roofing Repairs			2000	16,339	467	35	467		934	34
35	Roofing Repairs			2000	500	14	35	14		28	35
36	Fire Proof Attic			2001	182,492	5,214	35	5,214		5,214	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Replace Gutter	2001	$ 945	$ 27	35	$ 27	$	$ 27	37
38	Final costs for original construction of building	2001	273,858	7,825	35	7,825		7,825	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,056,240	$ 239,281		$ 203,045	$ (36,236)	$ 1,095,202	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 729,907	$ 109,712	$ 100,800	$ (8,912)	5-7	$ 584,997	71
72	Current Year Purchases	56,750	8,107	8,107		5	8,107	72
73	Fully Depreciated Assets	227,475					227,475	73
74								74
75	TOTALS	$ 1,014,132	$ 117,819	$ 108,907	$ (8,912)		$ 820,579	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Champion Motor Coach	1998	$ 46,392	$ 5,964	$ 6,627	$ 663	7	$ 26,508	76
77										77
78										78
79										79
80	TOTALS			$ 46,392	$ 5,964	$ 6,627	$ 663		$ 26,508	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,443,216	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 363,064	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 318,579	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (44,485)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,942,289	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 84,049 Description: Nrsg $56,152, Admin $21,805, Ancillary $6092
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility Use	1999 Plymouth Voyager	$ 409.00	$ 4,908	17
18					18
19					19
20					20
21	TOTAL		$ 409.00	$ 4,908	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 92.5

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 42

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		603	1,267		1,870
3	Classroom Wages	(a)	6,162	13,285		19,447
4	Clinical Wages	(b)	2,641	5,693		8,334
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			1,100		1,100
9	TOTALS		$ 9,406	$ 21,345	$	$ 30,751
10	SUM OF line 9, col. 1 and 2	(e)	$ 30,751			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	21
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	10
2. From other facilities (f)	
TOTAL TRAINED	31

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 2&3	hrs	$	7,076	$ 338,221	$ 10,993	7,076	$ 349,214	1
2	Licensed Speech and Language Development Therapist	10a, 2&3	hrs		1,461	67,074	477	1,461	67,551	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 2&3	hrs		8,021	404,728	10,272	8,021	415,000	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				417,014		417,014	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RT	10a, 2&3			1,259	49,786	23	1,259	49,809	13
14	TOTAL			$	17,817	$ 859,809	$ 438,779	17,817	$ 1,298,588	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lemont Center # 0041269 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 478,885	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,234,601		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	135,704		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,849,190	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	850,621		13
14	Buildings, at Historical Cost	8,355,728		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,062,984		16
17	Accumulated Depreciation (book methods)	(1,894,917)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,374,416	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,223,606	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 696,565	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	333,223		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	652,569		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Liabilities	4,088		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,686,445	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Inter Company Due To / From	14,863,767		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 14,863,767	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 16,550,212	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,326,606)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,223,606	$	48

***(See instructions.)**

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,569,638	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,569,638	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(9,892,033)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **2000 Corp Office Pd. 13 Adjustments**	3,978,295	15
16	Other (describe) **2001 Corp Office Pd 13 Adjustments**	(1,982,506)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (7,896,244)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,326,606)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,224,334	1
2	Discounts and Allowances for all Levels	(262,684)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,961,650	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,210,002	6
7	Oxygen	18,677	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,228,679	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	39,996	13
14	Non-Patient Meals	5,619	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	404,807	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	126,678	19
20	Radiology and X-Ray	83,307	20
21	Other Medical Services	514,959	21
22	Laundry	32,871	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,208,237	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	483	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 483	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	(2,183)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (2,183)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,396,866	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,282,541	31
32	Health Care	5,347,667	32
33	General Administration	5,969,838	33
	B. Capital Expense		
34	Ownership	704,180	34
	C. Ancillary Expense		
35	Special Cost Centers	6,902,323	35
36	Provider Participation Fee	82,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 20,288,899	40
41	**Income before Income Taxes (line 30 minus line 40)****	(9,892,033)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (9,892,033)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,432	1,820	$ 64,230	$ 35.29	1
2	Assistant Director of Nursing	881	1,023	25,265	24.70	2
3	Registered Nurses	33,960	37,745	929,616	24.63	3
4	Licensed Practical Nurses	18,916	20,979	410,775	19.58	4
5	Nurse Aides & Orderlies	106,359	116,822	1,478,191	12.65	5
6	Nurse Aide Trainees	4,386	4,472	27,345	6.11	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,897	14,200	175,635	12.37	10
11	Social Service Workers	6,323	6,308	127,475	20.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,855	29,061	282,132	9.71	15
16	Dishwashers					16
17	Maintenance Workers	3,638	3,902	51,592	13.22	17
18	Housekeepers	19,307	22,086	193,318	8.75	18
19	Laundry	7,921	8,498	60,650	7.14	19
20	Administrator	2,119	2,288	74,681	32.64	20
21	Assistant Administrator	578	612	9,128	14.92	21
22	Other Administrative	11,596	12,683	179,302	14.14	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,462	4,797	57,656	12.02	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	261,630	287,296	$ 4,146,991 *	$ 14.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	monthly	16,250	9, 3	36
37	Medical Records Consultant		2,689	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	per bed charge	7,400	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 26,339		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7,158	$ 327,777	10,3	50
51	Licensed Practical Nurses	4,156	142,420	10,3	51
52	Nurse Aides	10,550	214,221	10,3	52
53	TOTAL (lines 50 - 52)	21,864	$ 684,418		53

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sara Szumski	Administrator	0	$ 74,681
Other Administrative Salaries		0	195,511
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 270,192

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various	Accounting	$ 1,295
Bradley & Associates	Accounting	55
Legal Fees	Legal	9,000
	Contributions	27
Transworld System Corp	Collection	325
Sr. BOM	Collection	500
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 11,202

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 179,711
Unemployment Compensation Insurance	39,906
FICA Taxes	305,400
Employee Health Insurance	244,777
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan	13,180
Employee Expenses	13,949
Recruitment	250
TOTAL (agree to Schedule V, line 22, col.8)	$ 797,173

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
IL Health Care Assoc Dues	7,020
Subscriptions	1,280
Notary License	136
SAT Dues	140
APIC Dues	35
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,811

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,291
Seminar Expense	5,304
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,595

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lemont Center # 0041269 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL Health Care Assoc $7020**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **69,644** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **82,350**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **3,876**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NA**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KPMG Peat Marwick** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **Not Yet Available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

LEMONT
MEDICAID #: 22-3401506001
COST REPORT PERIOD : 01-01-01 THUR 12-31-01
SPECIAL COST CENTERS
Page 4 - Line 43

	REFER.	COST
Business Privilege Tax	V4.4303	-
Laboratory Fees	V4.4303	28,946
X-Ray Expense	V4.4303	47,766
		76,712

LEMONT
MEDICAID #: 22-3401506001
COST REPORT PERIOD : 01-01-01 THUR 12-31-01
MISCELLANEOUS REVENUE

Misc Revenue Summary	Amount
Prior period patient revenue	479
Cable Expense	2,068
Vendor Refunds	(332)
Garnishment Revenue	(32)
TOTAL	2,183